

VISTA@CARE CHILD CARE ELIGIBILITY APPLICATION

PLEASE SEE PAGE 2 FOR CERTIFICATION

Check One: Initial Application Redetermination Returning Member

Section A. FULL-TIME MEMBER AND HOUSEHOLD INFORMATION (Part-Time members are not Eligible)

1. Member Name

_____-_____-_____/_____/_____
Last First M.I. Social Security # Date of Birth
Work Telephone #: _____-_____-_____ Home Telephone #: _____-_____-_____

2. Mailing Address:

Number & Street

City

State

Zip Code

3. Please list all persons residing in your household. You must include all children and adults and their relationship to you (ie, spouse, aunt, mother, father, child, etc.). For any children under 13 years of age for whom you are legally responsible, please indicate if childcare through VISTA@CARE will be needed at any time (ie., current or future need). You must submit birth certificates for all children needing care.

Name of Household Member	SSN #	Date of birth	Relationship to Vista*Member	Gender (M/F)	If under 13 yrs. Does child need care? (Y/N)
VISTA MEMBER	N/A	N/A	Self	N/A	N/A

4. Are you currently receiving public subsidy for child care (do not include VISTA@CARE) for any of the children needing care listed in Item #3? **
Y/N _____

If Yes, please specify what type of subsidy. _____

5. Based on the information given in Item #3, indicate your family size below (remember to include yourself):

Family Size _____ # of Adults _____ # of Children _____

For ACV use only: CCDBG F.S. _____)

Section B. FAMILY INCOME For each source, enter income information on lines #1-7. Indicate gross monthly or yearly income. Eligibility is based on your family's monthly gross income and size. Your family must be determined eligible to receive child care benefits. Members must include their gross Vista living allowance on line #1.

Proof of income must be attached to the application (most recent 4 consecutive weeks)	a. Applicant	b. Spouse	c. Other household or family member	d. Other household or family member
	Income for Current month _____ year _____	Income for Current month _____ year _____	Income for Current month _____ year _____	Income for Current month _____ year _____
1. Wages & Salary (gross) includes VISTA allowance				
2. Pensions, Retirement, Social Security Benefits				
3. Unemployment, Worker's compensation				
4. Public Assistance (ie. AFDC)				
5. Child Support, Alimony				
6. Other:				
7. TOTAL INCOME				

****IT IS AGAINST FEDERAL REGULATIONS AND POLICIES FOR VISTA@CARE TO PAY FOR CHILD CARE WHILE THE MEMBER IS RECEIVING A CHILD CARE SUBSIDY FROM ANOTHER SOURCE.****

PLEASE CONTINUE ON 2ND PAGE

	State Program Office	Vista Work Site Information
1. Name of Vista Cluster (ie. Atlantic, Pacific, etc.)		
2. Vista State Program Officer NAME:		Phone #: () Fax #: ()
3. Complete Address (Street, City, State, Zip Code) for Vista Work Site		
4. VISTA Member's Start and Projected End Date. (DO NOT LEAVE THIS BLOCK BLANK)		Start: ____/____/____ End: ____/____/____ Yr. Member is service? (ie., 1,2,3) year
5. Will Member be required to attend PSO? If so, please indicate exact PSO dates. Did Member complete PSO? YES _____ NO _____	From ____/____/____ To ____/____/____	
6. Sign here to authorize VISTA@CARE to pay for child care during the Member's PSO training dates indicated in #5.	_____	
7. Will the Member be required to work weekends and/or evenings.	Check all that apply: evenings _____ week-ends _____	

CERTIFICATIONS

A. MEMBER CERTIFICATION: (Please read carefully, sign and date in designated areas)

As an active full-time member in VISTA, I certify that all of the above information is true and correct. I certify that I need childcare to be paid for in order to serve in VISTA. I understand that this information is being given in connection with federal funds, that agency officials may verify information, and that deliberate misrepresentation will result in denial of my application or termination of my child care benefits and/or my VISTA service. I also understand that any misrepresentations or falsification of information may result in **VISTA@CARE** reclaiming from me any money paid on my behalf. In addition, I certify that I am the parent or legal guardian/custodian of the child(ren) listed in Section A-3 and that I may be required to submit proof of such in order to receive child care benefits.

I have read the above paragraph and understand its content.

Applicant/Member Signature

_____/_____/_____
Date

B. STATE PROGRAM OFFICER CERTIFICATION: (Please read carefully, sign and date in designated areas)

I understand that the member must be income eligible to receive childcare benefits through **VISTA@CARE** and I have reviewed documents pertaining to the member's income.

I certify that _____ listed on page 1 of this application is eligible to receive

Applicant/Members Name

childcare benefits because she/he meets the following criteria:

- The applicant is a full-time VISTA member.
- The applicant's **total gross monthly household income** does not exceed the maximum income limit set by the state in which she/he lives. (Refer to state income eligibility chart).
- To the best of my knowledge, the member is the parent or legal guardian/custodian of the child(ren) listed in Section A-3
- The applicant will need childcare to be paid for in order to participate in the VISTA program.

State Program Officer Signature

_____/_____/_____
Date

St. Program Officer Name printed

Upon completion, please forward immediately to the Vista State Program Office. **VISTA@CARE** cannot process paperwork until approved by the State Program Officer. **All applications for childcare must have the State Program Officer's signature. Please allow 3-4 weeks for VISTA@CARE to process correct and complete paperwork.**

Please make copies and mail all original paperwork; We cannot guarantee receipt of paperwork sent via facsimile.

!!!!PLEASE FORWARD ALL PAPERWORK TO YOUR STATE PROGRAM OFFICE!!!!